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Appendix 5 Wisconsin Medicaid Covered Dental Services

This table should be used as a *general* guideline. For specific procedure codes and limitations, please see Appendices 9 through 19 of this handbook.

COVERED SERVICES	LIMITATIONS	NONCOVERED SERVICES
<i>Diagnostic Services:</i>		
Exams	-Two times a year (ages 1-12 years) -One time a year (ages 13 yrs. and over)	
Most X-rays	-Limits on frequency and type	
Office visit		-Not covered separately, provider should bill for treatment
<i>Preventive Services:</i>		
Cleanings (Prophylaxis)	-Two times a year (ages 1-12 yrs.) -One time a year (ages 13 yrs. and over) -Fluoride treatment for children without prior authorization	
Sealants	-Prior authorization required for some teeth -One time every three years	
Space Maintainer	-For children only, prior authorization required for ages 13-20	
<i>Restorative Services:</i>		
Fillings	-One time a year for baby teeth, if needed -One time every three years for permanent teeth, if needed	
Crowns	-Prefabricated stainless steel crowns -Other prefabricated crowns for front teeth -Prior authorization required for adults for non-stainless steel prefabricated crowns for front teeth	-Single unit crowns, not prefabricated
<i>Endodontic Services:</i>		
Anterior, Bicuspid Root Canals	-Adults require prior authorization -Only covered if good oral health, good attendance record, few missing teeth	
Molar Root Canals	-Prior authorization required for everyone -Only covered if good oral health, good attendance record, few missing teeth	

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Appendix 5
Wisconsin Medicaid
Covered Dental Services
 (continued)

COVERED SERVICES	LIMITATIONS	NONCOVERED SERVICES
<i>Periodontal Services:</i>		
Gingivectomy	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Scaling and Planing	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Full-mouth debridement	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
Periodontal maintenance procedure	-Prior authorization required	-Osseous surgery and all other adjunctive periodontal services
<i>Dentures-Bridges:</i>		
Partial Dentures	-Require prior authorization -Covered only if good oral health and specific teeth missing -Six-week healing period after extraction -Only resin base partials -Replacement once per five years, if needed	-Cast metal base partial dentures
Full Dentures	-Prior authorization required -Replacements only once per five years, if needed -Six-week healing period after extraction	-Duplicate, overlay, cu-sil dentures
Denture Reline	-Prior authorization required -Only once per three years	
Denture Repair	-Limited reimbursement for repair -Repair only if denture is repairable	
Bridges	-Fixed bridge requires prior authorization -Fixed bridge coverage extremely limited	
<i>Oral Surgery:</i>		
Tooth Extraction	-Surgical tooth removal covered only in medical emergency	-Surgical tooth removal without emergency conditions
Oral Surgeries	-Some require prior authorization	-Alveoplasty, vestibuloplasty, and osteoplasty after age 20
TMJ Surgery	-Covered only if non-surgical treatment was unsuccessful	-Non-surgical treatment of TMJ
General or IV Anesthesia	-Requires prior authorization -Covered only when medically necessary	
<i>Orthodontia:</i>		
Orthodontia	-Requires prior authorization -Children up through age 20 -HealthCheck referral required -Covered only in cases of severe malocclusion	-Adult orthodontia

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Appendix 5
Wisconsin Medicaid
Covered Dental Services
(continued)

The following services are not Wisconsin Medicaid covered services:

- Cast metal base partial denture
- Overlay, cu-sil, duplicate dentures and adjustments.
- Dental implants and transplants.
- Services for purely aesthetic or cosmetic purposes.
- Cast and prefabricated post and core.
- Professional visits including office visits in which no treatment occurs.
- Single unit cast crowns.
- Adult orthodontia.
- Dispensing of drugs.
- Adjunctive periodontal services.
- Alveoplasty, vestibuloplasty, and most osteoplasty.
- Non-surgical medical or dental treatment for a TMJ condition.
- Service for which prior authorization was denied.

Copayment

Copayments are an important part of reimbursement for dental services. Recipients are encouraged to make every effort to pay their copayment.

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Appendix 6
Multidisciplinary Temporomandibular Joint Evaluation Programs
Approved By The Wisconsin Department of Health and Family Services
Medicaid Program

The following programs have been approved as multidisciplinary Temporomandibular Joint (TMJ) Evaluation Programs for Wisconsin Medicaid:

A. Thomas Indresano, D.D.S.
Professor and Chairman
Oral and Maxillofacial Surgery
Medical College of Wisconsin
Milwaukee County Medical Complex
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
(414) 454-5760

William J. Nelson, D.D.S.
Oral and Maxillofacial Surgery
Associates of Green Bay, S.C.
704 Webster Avenue
Green Bay, WI 54301
(920) 468-3400

Michael P. Banasik, D.D.S.
Department of Dental Specialist
Gundersen Clinic, Ltd.
1836 South Avenue
LaCrosse, WI 54601
(608) 782-7300, extension 2260

John F. Doyle, D.D.S.
University of Wisconsin Hospital and Clinics
600 Highland Avenue
Madison, WI 53705
(608) 263-7502

Daniel J. D'Angelo, D.D.S.
Oral and Maxillofacial Surgery
Associates of Waukesha, Ltd.
1111 Delafield Street #321
Waukesha, WI 53188
(414) 547-8665

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Appendix 7

Example of Prescription for Specialized Medical Vehicle Trips That Exceed Upper Mileage Limits

Specialized medical vehicle (SMV) providers must obtain prior authorization for all SMV trips (except for hospital and nursing home discharges) that:

- ♦ Originate in one of the urban counties listed below and exceed 40 miles one-way.
- ♦ Originate in any other county and exceed 70 miles one-way.¹

Prior authorization requires a prescription from the referring provider.²

Urban counties are: Brown, Dane, Fond du Lac, Kenosha, LaCrosse, Manitowoc, Milwaukee, Outagamie, Sheboygan, Racine, Rock, and Winnebago.

If you refer a recipient who needs SMV transportation to a medical service that you suspect is farther away than the Wisconsin Medicaid upper mileage limits, write a prescription for the recipient to show the SMV provider.

Your prescription should include the name of the health care provider or facility, city where it is located, the service the recipient requires, and the amount of time the recipient needs transportation to the service (indicate time in days, not to exceed 365 days).

Anytown Clinic 1 W. Willow Anytown, WI 55555	
Name	<i>I. M. Recipient</i>
Address	<i>609 Willow Anytown, WI 55555</i> <i>Regional Clinic, Anytown</i> <i>Emergency Dental Services</i> <i>Round trip--Recipient's home to Regional Clinic, Anytown</i> <i>95 miles</i>
Prescriber's Signature	<i>I. M. Referring, D.D.S.</i> <div style="text-align: right; padding-top: 10px;"> Date <i>MM/DD/YY</i> </div>

¹HFS 107.23(2)(f), Wisconsin Administrative Code

² Providers who may refer recipients and write SMV prescriptions are physicians, physician assistants, nurse midwives, nurse practitioners, dentists, optometrists, opticians, chiropractors, podiatrists, HealthCheck agencies, and family planning clinics.

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Appendix 8 Place of Service Codes

Wisconsin Medicaid uses place of service codes to indicate where the service was provided. Many dental procedure codes have place of service restrictions. Below is a list of place of service codes and their descriptions:

<u>Place of Service (POS) Description</u>	<u>HCFA POS</u>
Other	0
Inpatient Hospital	1
Outpatient Hospital	2
Doctor's Office	3
Home	4
NH/Extended Care Facility	7
Skilled Nursing Facility	8
Ambulatory Surgery Center	B

Refer to the individual appendices within this section for information on specific place-of-service requirements.

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Appendix 9 Diagnostic Services

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
<i>Clinical Oral Examinations:</i>				
00120	Periodic Oral Examination	No	All	One per 12-month period per provider for ages 13 and older. One per six months per provider for ages 0 through 12.
00150	Comprehensive Oral Evaluation	No	All	One per three years per provider.
00160	Detailed and extensive oral evaluation-problem focused, by report	No	All	One per three years per provider.
W7060	Periodic Oral Exam (Additional) - HealthCheck other services	Yes	13-20	Up to two additional oral exams per year with a HealthCheck referral.
W7130	TMJ Office Visit	No	All	One per year per provider.
<i>Radiographs:</i>				
00210	Intraoral, complete series (including bitewings)	No*	All	One per three years per provider Not billable within six months of other x-rays including 00220, 00230, 00240, 00270, 00272, 00274, 00330 except in an emergency. ¹ (Panorex plus bitewings may be billed under 00210.)^
00220	Intraoral - periapical, first film	No	All	One per day Not billable for same date as, or six months after, 00210.^
00230	Intraoral - periapical, each additional film	No	All	Up to three per day Must be billed with 00220 Not billable for same date as, or six months after, 00210.^

Key:

- ¹ - Retain records in recipient files regarding nature of emergency.
- * - Frequency limitation may be exceeded only with prior authorization.
- ^ - Six-month limitation may be exceeded in an emergency as indicated by "E" on the claim form. The same date of service limitation may *not* be exceeded in an emergency.

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Appendix 9 Diagnostic Services (continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
00240	Intraoral - occlusal film	No	All	Up to two per day Not billable for same date as 00210.
00250	Extraoral - first film	No	All	<i>Emergency only</i> , one per day. ¹
00260	Extraoral - each additional film	No	All	<i>Emergency only</i> , only two per day. ¹ Must be billed with 00250.
00270	Bitewing - single film	No	All	One per day, up to two per six-month period, per provider. Not billable for same day as, and for six months after, 00210, 00270, 00272, or 00274. [^]
00272	Bitewings - two films	No	All	One set of bitewings per six-month period, per provider. Not billable for same day as, and for six months after, 00210, 00270, 00272, or 00274. [^]
00274	Bitewings - four films	No	All	One set of bitewings per six-month period, per provider. Not billable for same day as, and for six months after, 00210, 00270, 00272, or 00274. [^]
00330	Panoramic Film	No*	All	<i>Emergency only</i> , or orthodontia diagnostic only with prior authorization. ¹ One per day when another radiograph is insufficient for proper diagnosis Not billable with 00210, 00270, 00272, or 00274.
00340	Cephalometric Film	Yes	All	Orthodontia diagnosis only.
<i>Tests and Laboratory Examinations:</i>				
00470	Diagnostic Casts	Yes	All	Only upon DHFS request.

Key:

- ¹ - Retain records in recipient files regarding nature of emergency.
- * - Frequency limitation may be exceeded only with prior authorization.
- [^] - Six-month limitation may be exceeded in an emergency as indicated by “E” on the claim form. The same date of service limitation may not be exceeded in an emergency.

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Appendix 9 Diagnostic Services (continued)

COVERED SERVICES

DEFINITION	<p>Diagnostic services include oral evaluations, selected radiographs, and diagnostic casts to:</p> <ul style="list-style-type: none"> - Assess oral health. - Diagnose oral pathology. - Develop an adequate treatment plan for the recipient's oral health. <p>Dentists are required to bill the oral evaluation procedure appropriate to the level of service provided.</p> <p>Children ages 13-20 may receive up to two additional oral evaluations per year through HealthCheck. These additional evaluations must be prior authorized.</p>
ORAL EVALUATION DOCUMENTATION	<p>Dentists must document and maintain oral evaluation information in the same manner as they do for other patients. Wisconsin Medicaid regulations and accepted standards of dental care require documentation of:</p> <p>Periodic Oral Evaluation</p> <ul style="list-style-type: none"> - Changes in dental and medical health since the last oral evaluation. - Diagnosis of dental diseases. - Interpretation of information acquired through additional diagnostic procedures. <p>Comprehensive Oral Evaluation</p> <p>Documents:</p> <ul style="list-style-type: none"> - Review of medical and dental history including chief complaint. - Blood pressure; baseline and additional, if appropriate. - Intra-and extra-oral soft and hard tissue examination. - Charting of the dentition, restorations, and periodontal conditions (including periodontal charting and tooth mobility). - Occlusal relationships. - Dental diagnosis and treatment plan. - Interpretation of information acquired through additional diagnostic procedures. <p>Detailed and Extensive Oral Evaluation</p> <ul style="list-style-type: none"> - Problem-focused findings of comprehensive evaluation. - Integration of more extensive diagnostic modalities. - Diagnosis, prognosis, and treatment plan.
RADIOGRAPHS	<p>Only a limited number and variety of radiographs are covered. Reimbursement for radiographs includes exposure of the radiograph, developing, mounting, and radiographic interpretation.</p> <p>An intraoral complete series may include either a periapical series plus bitewings or a panorex plus bitewings. Individual panoramic radiographs are covered in emergency situations or for orthodontia diagnosis only.</p>

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Appendix 9 Diagnostic Services (continued)

ORAL EVALUATIONS DONE IN NURSING HOMES OR FOR CHILDREN To provide greater flexibility in scheduling when oral exams are provided to an adult nursing home resident or to children, the time period between oral evaluations may be as few as 330 days for adult nursing home residents and 160 days for children.

DETAILED AND EXTENSIVE ORAL EVALUATION Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complex temporomandibular dysfunction, facial pain of unknown origin, or severe systemic diseases requiring multi-disciplinary consultation.

PRIOR AUTHORIZATION

FULL MOUTH RADIOGRAPHS Additional full mouth (intraoral complete series) radiographs or panoramic x-rays can receive prior authorization in cases of trauma or other unusual medical or dental clinical histories, such as cancer or rampant decay.

CEPHALOMETRIC RADIOGRAPHS Cephalometric radiographs are allowed only for orthodontic cases and always require prior authorization (PA) and a HealthCheck exam.

PANORAMIC RADIOGRAPHS Panoramic radiographs for orthodontic cases also require a PA and a HealthCheck exam.

BILLING

BILLING RADIOGRAPHS All x-rays provided on the same date of service are required to be billed on the same claim form. Duplicate billings are denied.

DETAILED AND EXTENSIVE ORAL EVALUATION Claims for detailed and extensive oral evaluation are required to be filed on paper with a copy of the office progress notes to document the medical necessity for an extensive problem-focused evaluation.

EMERGENCY SERVICES Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the American Dental Association (ADA) claim form does not have a means to designate emergency treatment by procedure, all claims for emergency services must be identified by an "E" in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. Only the letter "E" without any additional letters is accepted. Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Wisconsin Medicaid covered diagnostic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

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Appendix 10 Preventive Services

Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
<i>Dental Prophylaxis:</i>				
01110	Prophylaxis - adult	No* (see limitations)	>12	<p>One per 12-month period per provider.</p> <p>Three additional per year allowable with prior authorization.</p> <p>Not billable with periodontal scaling and root planing or periodontal maintenance procedure or periodontal scaling performed in presence of gingival inflammation.</p> <p>(Prior authorization may be granted for up to five years for permanently disabled recipients.)</p>
01120	Prophylaxis - child	No* (see limitations)	<13	<p>One (01120 or 01201) per six months per provider.</p> <p>Up to two additional per year allowable with prior authorization.</p> <p>Not billable with 01201.</p> <p>(Prior authorization may be granted for up to five years for permanently disabled recipients.)</p>
<i>Topical Fluoride Treatment (office procedure):</i>				
01201	Topical application of fluoride (including prophylaxis) - child	No* (see limitations)	<13	<p>One (01120 or 01201) per six months per provider.</p> <p>Up to two additional allowable per year with prior authorization.</p> <p>Not billable with 01120.</p> <p>(Prior authorization may be granted for up to five years for permanently disabled recipients.)</p>

Key:

* - Frequency limitation may be exceeded only with prior authorization.

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Appendix 10 Preventive Services (continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
01203	Topical application of fluoride (prophylaxis not included) - child	Yes (see limitations)	<13	Up to four per year with prior authorization. (Prior authorization may be granted for up to five years for permanently disabled recipients.)
01204	Topical application of fluoride (prophylaxis not included) - adult	Yes (see limitations)	>12	Up to four per year with prior authorization. (Prior authorization may be granted for up to five years for permanently disabled recipients.)
01205	Topical application of fluoride (including prophylaxis) - adult	Yes (see limitations)	>12	Up to four per year with prior authorization. Not billable with periodontal scaling and root planing. (Prior authorization may be granted for up to five years for permanently disabled recipients.) One per six-month period, per provider.
<i>Other Preventive Services:</i>				
01351	Sealant - per tooth	Yes (see limitations)	< 21	Prior authorization <i>is not</i> required for tooth numbers 2, 3, 14, 15, 18, 19, 30, 31. Prior authorization <i>is</i> required for tooth numbers 1, 4-13, 16, 17, 20-29, 32, A-T, SN. Narrative required in order to exceed once per three-year limitation on permanent first and second molars.

Key:

* - Frequency limitation may be exceeded only with prior authorization.

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Appendix 10 Preventive Services (continued)

Proc. Code	Description of Service	PA Required?	Allowable Age	Limitations
<i>Space Maintenance (passive appliances):</i>				
01510	Space maintainer - fixed - unilateral	No	< 21	First and second primary molar only (tooth letters A, B, I, J, K, L, S, T only). Limited to four per day; once per year per tooth. A narrative is required to exceed the limitation.
01515	Space maintainer - fixed - bilateral	Yes (see limitations)	< 21	Once per year, per arch. Prior authorization is required only for ages 13-20. Narrative required to exceed frequency limitation, before age 13.
01550	Recementation of space maintainer	No	< 21	Limited to two per day.

Key:

* - Frequency limitation may be exceeded only with prior authorization.

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Appendix 10 Preventive Services (continued)

PROPHYLAXES

COVERED SERVICES

ROUTINE PROPHYLAXIS SERVICES

Preventive services include routine prophylaxes (which includes scaling and polishing) for adults and children.

Wisconsin Medicaid covers routine prophylaxes including scaling and polishing:

- Once every six months for children through age 12.
- Once per year for recipients over the age of 12.
- Children ages 13-20 may receive one additional prophylaxis per year with prior authorization (PA).

PROPHYLAXIS SERVICES DONE IN A NURSING HOME OR FOR CHILDREN

To provide greater flexibility in scheduling when oral exams are provided to an adult nursing home resident or to children, the time period between oral evaluations may be as few as 330 days for adult nursing home residents and 160 days for children.

PROPHYLAXES AND FLUORIDE

When prophylaxes and fluoride are provided on the same date of service, they must be billed under a single procedure code rather than as two separate procedure codes.

PRIOR AUTHORIZATION

ADDITIONAL PROPHYLAXES COVERAGE

Additional prophylaxes are a covered benefit for recipients only with PA. The criteria for approval of additional prophylaxes require one or more of the following conditions:

- Mental or physical handicaps which impair oral hygiene.
- Recipient is taking medication which causes gingival hyperplasia.
- Recipient has another medical condition requiring additional prophylaxes.

A plan of care regimen with additional prophylaxes is routinely granted for 12 months, unless a longer period is specified in the PA request.

EXTENDED PRIOR AUTHORIZATION

PA for additional prophylaxes treatments for disabled recipients can be granted for up to five years if:

- The disability is permanent.
- The provider expects to see the recipient over an extended period of time.

DOCUMENTATION FOR PROPHYLAXES

The following information must be submitted on the PA request:

- Complete description of the recipient's oral condition.
- Past dental and medical history.
- Etiologic factors affecting the recipient's oral condition.
- Anticipated treatment plan and fees, including additional prophylaxes and fluoride treatment.

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Appendix 10
Preventive Services
 (continued)

PRIOR AUTHORIZATION
 (continued)

To obtain PA for more than 12 months, indicate (in addition to the information required on all PAs listed above) on the Prior Authorization Dental Request Form (PA/DRF) and Prior Authorization Dental Attachment (PA/DA):

- The period of time for which you are seeking PA.
- A statement to explain the permanency of the disability.
- The total number of annual and semi-annual prophylaxes requested. For example, if the recipient is a regular patient with a permanent disability, you can request three additional prophylaxes per year for five years (a quantity of 15 on the PA/DRF).

TOPICAL FLUORIDE TREATMENT

COVERED SERVICES

DEFINITION Topical fluoride treatment is a covered benefit for children and adult recipients.

The application of topical fluoride treatment is allowed for children:

- Up to age 13.
- Once every six months.
- In conjunction with a prophylaxis.
- Without PA.

PRIOR AUTHORIZATION

DEFINITION PA is required for fluoride services for children under age 13 in excess of one treatment per six months and for any fluoride treatment for recipients age 13 and over.

ADDITIONAL FLUORIDE TREATMENT FOR CHILDREN Up to two additional fluoride treatments per year may be approved for recipients under age 13 with PA.

FLUORIDE TREATMENT FOR ADULTS Fluoride treatments for recipients age 13 and over are covered if approved with PA.

CRITERIA FOR COVERAGE The criteria for approval of topical fluoride treatment require one or more of the following conditions:

- Rampant decay.
- Xerostomia.
- Radiation therapy to the head and neck.
- Cemental or root surface caries secondary to gingival recession.

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Appendix 10 Preventive Services (continued)

- Mental and physical handicaps which impair oral hygiene resulting in high incidence of caries.

A plan of care regimen for topical fluoride treatment is routinely granted for 12 months, unless a longer period is specified in the prior authorization (PA) request.

EXTENDED PRIOR AUTHORIZATION

PA for topical fluoride treatment for disabled recipients can be granted for up to five years if:

- The disability is permanent.
- The provider expects to see the recipient over an extended period of time.

The following information must be submitted on the PA request:

- Complete description of the recipient's oral condition.
- Past dental and medical history.
- Etiologic factors affecting the recipient's oral condition.
- Anticipated treatment plan and fees, including additional prophylaxes and fluoride treatments.

To obtain PA for more than 12 months, in addition to the information required on all PA requests listed above, indicate on the PA/DRF and PA/DA:

- The period of time for which you are seeking PA.
- A statement to explain the permanency of the disability.
- The total number of fluoride treatments requested. For example, if the recipient is a regular patient with a permanent disability, you could request four fluoride treatments per year for five years (a quantity of 20 on the PA/DRF)

SEALANTS

COVERED SERVICES

HEALTHCHECK NO LONGER REQUIRED

Sealants are a covered service for recipients under 21 years of age. As of January 1, 1998, Wisconsin Medicaid no longer requires a HealthCheck exam before a recipient receives sealants.

Wisconsin Medicaid covers sealants (ADA procedure code 01351) for a child once every three years.

PRIOR AUTHORIZATION

DEFINITION

Sealants on the first and second permanent molars do not require PA. PA is required for sealants on all other teeth.

PA is required for tooth numbers 1, 4-13, 16, 17, 20-29, 32, A-T, SN.

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Appendix 10
Preventive Services
 (continued)

SPACE MAINTAINERS

COVERED SERVICES

DEFINITION

Space maintainers are a covered Wisconsin Medicaid service. Space maintenance therapy is covered to enable children to develop normal dental occlusion. This service includes coverage of missing anterior teeth, bilateral missing posterior teeth, and unilateral missing posterior teeth.

A space maintainer which includes a stainless steel crown (loop or distal shoe types) is reimbursed as a spacer plus a stainless steel crown. When a stainless steel crown is used instead of a band, the stainless steel crown must be separately identified.

PA is required for the space maintainer, fixed bilateral type, for children ages 13-20.

**SPACE MAINTAINERS
DOCUMENTATION**

The PA request for space maintainers must include:

- Two bitewing radiographs.
- Anterior periapical radiograph for anterior space maintainers.
- A dentist's statement documenting one of the following:
 1. Evidence of premature loss of one or more primary teeth on both sides of the arch.
 2. Congenital absence of permanent teeth.
 3. Delayed eruption pattern due to certain medical conditions.
 4. Presence of supernumerary teeth.

ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Wisconsin Medicaid covered preventive services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

